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ABSTRACT

The health care organization, as a specialized organizational setting, has some characteristics that make it of special concern to the conflict theorist. In a health care setting, conflict may arise as a result of (1) the complexity of medicine and the bureaucracy of health care delivery, (2) the problems of acquiring relevant information from patients compounded by the proliferation of specializations in the health care field and the probability that areas of technical expertise may not match perceived images of credibility on the part of those seeking treatment, (3) the need for accurate receipt of information and compliance about medication regimens, (4) the problems of health professionals working together from a base of extreme heterogeneity, and (5) the need to relate the function of a health care organization to its relationship with the community. These potential problems underscore the need for a thorough grounding in conflict theory and management principles and techniques for all health care professionals as part of their educational backgrounds. (Interviews with key personnel at two hospitals in northwest Ohio are appended.) (HOD)

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TEACHING CONFLICT MANAGEMENT SKILLS

TO THE

HEALTH CARE PROFESSIONALS

Speech Communication Association

of Ohio

Columbus, October, 1980

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In the summer of 1980, two senior level communication majors at Bowling Green, in an independent study project designed as a follow-up to a course in medical communication offered the previous spring, conducted a series of personal in depth interviews with key personnel at hospitals in Northwest Ohio. Their purpose was to gain qualitative insight into assumptions about and methods of handling organizational conflict situations. Four interview summaries are part of this paper; they represent two individuals at each of two hospitals. Interviews A and D represent the first and B and C represent the second hospital. Qualitative analysis and interpretation of the interview data suggests the following about Hospital One (A and D) and Hospital Two (B and C).

Hospital One

1. Conflict is accepted as inevitable in the organization; it is assumed that it will normally occur.
2. Organizational structure is designed in such a way as to be immediately sensitive to conflict situations, and channels (both oral and written) for upward directed messages (concerns, complaints, etc.) are in existence.
3. Personnel with expertise are designated to deal with conflict situations.
4. Regular meetings among staff occur at which individuals express feelings and have the opportunity to understand and perhaps resolve differences.
5. Immediate attention to conflict situations in which people involved are brought together.
6. Emphasis on workshops, seminars, etc. on such matters as stress management transactional analysis.
7. Emphasis on information dissemination is featured through both house organs and meetings.
8. Semi-regular contact between the organization's president and

employees in which concerns are responded to after they have been submitted in advance.

9. A concerted non-defensive reception on the part of supervisors and department heads to complaints.

Hospital Two

1. Conflict is accepted as potentially deviant behavior involving violation of rules.
2. Organizational structure is sufficiently rigid and rule oriented to suppress conflict or else to minimize its consequences.
3. Personnel perceived to be in conflict are dealt with separately rather than together - - if transfer is possible it is effected. Group methods of coping are avoided.
4. Concerns and complaints are evaluated or judged as either legitimate or not.
5. Information dissemination as well as information receptivity is limited.
6. Regular group meetings among staff at any level do not occur (except the dietary staff who meet monthly to plan menus).

The preceding is not a definitive data-gathering and interpretation effort. It does, however, provide enough to raise seriously the questions in anyone's mind: Would assumptions and practices regarding conflict make any possible difference in health care? Would you as reader, all other things being equal, prefer one hospital to the other given this information?

Hospital One, interestingly, has been strong of late in Northwest Ohio in promoting a health concept known as "wellness" - - the emphasis being on maintaining health through proper diet, exercise, stress management, etc. The "wellness" approach assumes that preventitive medicine is the best medicine. If we might analogize , Hospital One also seems to be assuming

that preventitive medicine is best in conflict management, as they clearly exhibit organizational features designed to minimize dysfunctional conflict.

Appropriate organizational structures and climates, however, do not eliminate conflict, they simply diminish the chances that conflict will create serious dysfunctions. The health care organization, as a specialized organizational setting, has some characteristics that make it of special concern to the conflict theorist. Its uniqueness may demand special treatment. (The first three of the following characteristics are borrowed from Wilcox and Wilcox, 1979)

First, coordination of health care, in systems terms, is a complex problem. Of late, the health care professions have experienced development of a new concept--the team approach to medical care. The complexity of medicine and the bureaucracy of health care delivery have resulted increasingly in teams of health professionals--physicians, nurses and pharmacists (Davis, Crigler, and Martin, 1977). In a hospital or family practice center, of course, the organizational structure creates an environment in which coordination is possible because of greater role clarity of both professional and patient:

> The physician, as the team captain, acquires a data bases, assesses the problems and initiates a treatment plan. The nurse is involved in direct patient care by aiding the physician, screening patient problems, follow-up, and dissemination of patient education materials. The pharmacist works on patient education, acute and chronic therapy compliance, monitoring chronic patients, calculating dosage and screening for adverse reactions and drug interactions (Davis, Crigler, and Martin, 1977).

Whatever communication problems may result within such an organization as professionals (ideally) cooperate toward the goal of patient care are many times magnified outside the organizational context where health care "system" or "team" become abstractions and patients may not be the beneficiaries of

coordinated treatments and may be unaware that they are not, or unaware of the need to be. It is a fact that about 80 per cent of all patients receive medication or drugs in an ambulatory setting (outside of the supervised organizational setting) and therefore are given primary responsibility for administering prescribed medications (White, Williams, and Greenburg, 1961).

It is also a fact that it is possible for a single individual to be treated by a general practitioner, medical specialist(s), a dentist, etc. -- all of whom may prescribe medication, unaware of the prescriptions of other professionals. It is further possible for that individual to fill prescriptions at different pharmacies. All too frequently the patient is in no position to exercise intelligently the responsibility for administering treatments and medications. The need for health professionals to acquire considerable skill both in obtaining information and in counseling and educating patients should be clear and should emphasize the need for interpersonal skills. Coordination of a system is difficult enough when the system is an organization with clear role specializations and some tangible boundaries; it is much more difficult outside that context, especially when the patient assumes considerable coordination responsibility. Helping the patient assume that responsibility is a critical communication function for the health professional.

Second, matching expertise with credibility can create conflict potential. The problem of acquiring relevant information (case histories, etc.) from patients as well as counseling and educating them is compounded by proliferating specializations in the health care field and the probability that areas of technical expertise may not match perceived images of credibility on the part of those seeking/receiving treatment and health professionals themselves. It is safe to say the medical care complex is dominated by the physician M.D. as the ultimate authority in the public mind, particularly the specialist. It is further safe to indicate that the pharmacy profession is all too conscious of its public image as "over-the-counter" syrup pourers and pill dispensers.

The triangular pattern of interaction among physician, patient, and pharmacist and the consequent feelings of negative and positive transference is discussed at length by a psychiatrist (Clifford, 1979) recently, illuminating the adverse image consequences possible and likely in these relationships. Suffice it to say that most health professionals are at least tempted to question the authority or expertise of other health professionals, with or without legitimate reason, leaving the patient either excluded from or confused about, status and authority relationships of the professionals they seek treatment or medication from. Health professionals need to acquire a sense of identity as a component in a system of interdependent components and a skill in interacting with other professional components of the health care system as a prerequisite to accurately communicating appropriate images of expertise to the public.

A recent development in California underscores the importance of this kind of accurate communication. Legislation provides for ten pilot projects permitting prescribing, dispensing, and administration of drugs by registered nurses, physicians' assistants, and pharmacists under general physician supervision. This represents an added dimension of responsibility and professional authority. In an editorial describing this legislation, the author asks "Who writes a good prescription?" His own answer is that the person who has a fund of knowledge about the patient, drugs, and therapeutics and the disease or presented complaint is the one who can write a "good" prescription. Pharmacists, of course, have an excellent, if not superior knowledge of drugs and therapeutics, but do they know enough about the patient and disease pathology to write that "good" prescription? (Oliver, 1979)

Unasked by the editorial writer are two obvious questions--does the physician know enough about drugs and therapeutics? and from the communication scholar's point of view, who will write a "credible" prescription? Credible that is, from the patient's point of view as part of a public that has little

basis for knowing who writes a good prescription other than the image of physician as ultimate authority on all matters medical.

Third, the need to develop and maintain appropriate health professional/patient relationships. Compliance with medication regimens is dependent on several factors including: understanding information and instructions (Boyd, Covington, Stanaszek and Coussons, 1974), perception of susceptibility to illness (Crichton, Smith, Demanuele, 1978), emotional readiness and motivation (Zifferblatt, 1975), attitudes about drug and disease (Davis, 1978), patient dissatisfaction with physician visit (Schwartz, 1962), lengthy waiting period for both physician writing and pharmacist filling of prescriptions (Geersten, Gray and Ward, 1973), inadequate coping mechanisms for fear of disease (Gillum, and Barsky, 1974) -- to name a few. Clearly then, the problem of compliance is not simply a matter of providing volumes of information, however much clarity is aided by illustration, restatement or simply vocabulary, though even that is a significant answer (Smith, 1976).

The accurate receipt of information and compliance is best enhanced by the quality of the patient relationship, a relationship in which the patient trusts and has confidence in the professional, feels like a partner in planning and assumes responsibility for carrying out a regimen, feels free to ask questions, and particularly feels as if the health professional cares about him or her (Smith, 1976). The latter factor, in particular, seems to be associated with recovery rate. The health professional's arsenal of therapeutic strategies then must include more than information, however clear, however much, however presented (slides, brochures, filmstrips, etc.); it must also include the ways of establishing relationships with patients which augment all other health care strategies. Relational development then is a critical interpersonal skill.

Fourth, when the health care system is functioning even at its coordinated best, it involves individuals working together from a base of extreme

heterogeneity. Age differences (and we are aware, of course, of the chronic, non-compliant, older) educational differences (orderlies vs. M.D. specialists), status differences (LPN vs. RN) or role uncertainties (are nurses primarily order-followers or primarily decision-makers?) and value differences (a nurse's horror at having to minister to a young unmarried patient with VD) are major contributors to this heterogeneity of background. As communication theorists know, when people of differing backgrounds work in close proximity, when status differences exist and any role disagreement is present, the potential for conflict is clear. In all probability, the majority of conflicts are relational and spring from the question "who has the right to do what to whom, and how, and when?" This may be a critical question in the health care setting, more so than popularly believed.

Finally, the ultimate function of a health care organization and its relationship to the community or society of which it is a part may serve to diminish the possibility of ideal conflict management. The sanctity of the healing profession in our society, the need in some cases for rapid decision making, the fact that health care organizations (esp. hospitals) are extremely competitive, and the current potential for malpractice suits provide greater incentive to see conflict as a deviation rather than a norm and to suppress rather than open it to the possible scrutiny of many.

The preceding should serve to underscore the need for a thorough grounding in conflict theory and management principles and techniques for virtually all health care professionals as a part of their educational backgrounds. If not an entire course, then conflict study should occupy a healthy portion of an interpersonal communication course. In our judgment, a two day workshop won't do -- it has all the curative properties of a band aid.

Several texts on conflict are available for the upper level undergraduate or even graduate student. We particularly endorse Interpersonal Conflict (Frost and Wilmot, 1978). Its discussions in particular, of conflict as

potentially constructive (as well as destructive), of power, strategic planning, tactical choices (esp. the quid pro quo), and intervention tactics are thoroughly consistent with current conflict literature and highly applicable to organizational settings. At this point, how conflict management is taught and for how long it is taught, is less important than that it be taught.

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INTERVIEW A

Q: Tell us about conflict between administration versus employees.

A: We improve it through employee communication, such as Dialogue, Extra . . . . We try to be open with our employees. We try and make it look like we're not trying to hide anything from them. We do have questions that do come in for our Friday Forum and we have a committee that goes over the answers. I'll take the question over to whoever I feel is qualified to answer it. Then these people come back to the committee when they meet to go over the answer. We make enough copies for everyone at that committee which is usually fifteen so that Nursing has some idea what Maintenance is doing, and Maintenance has an idea what the custodial department is doing, etc. This committee looks at three different things: 1) Whether the question has been answered, 2) Whether they've answered the question , and 3) If the question has been answered in the same context or attitude it has been asked in. We also have besides the Friday Forum, what is called the Second Page (of the Friday Forum). The Second Page is for those who want to express an opinion but don't necessarily want to ask a question. Many just want to express an idea or feeling or an opinion. They go unsigned. It goes a little slow right now, but once more people use the Second Page and are not afraid to identify themselves it will be more beneficial. What I'm trying to do is to alleviate that conflict and get it out of them by doing it publicly. This way people can find out that other people feel the same way they do and something should be done. Alot of times there are rumors that go around and we want to make sure they get the facts and that's one way through the Second Page, Forum and the Dialogue can get the facts out to the people.

We also have something that's just come out called In the Works. It used to be part of the Dialogue, but now it is a separate publication. The whole purpose behind this is to let people know that things around the hospital, such as the new carpeting or new color of the walls in the cafeteria,

etc. will be completed by such and such a date and right now it's All in the Works. Just keep your judgments till everything is finished. We let the workers know why things have been completed and the detail that goes into it.

For a moral booster we have what is called That's Our Spirit. People are asked to write in about someone or something that is doing a super job and then can get the recognition they deserve.

I want to tell you about our President-Employee talks because they are very key to conflict management. We have a very young, innovative President here. He has a background in Speech Communications from ; he also has his law degree from . He is years old. He holds President-Employee talks three times a year, where he comes in on the 24 hour period. Employees submit their question before that, we type them up and then in turn these questions are given to him. In addition, supervisors and dept. heads are not invited to these talks. The only administration invited are Ms. and myself. Me for attitude feelings, not specifics. She's ( )looking for specifics; where can they improve employee problems. I look for where to gear Public Relations. It's a very free feeling type of atmosphere. And they can ask just about anything they want to, and they really do. He answers them very honestly and they are told <u>why</u> things are such.

INTERVIEW B

Q: How do you handle complaints from your patients here at ?

A: Our administrator makes rounds of the hospital and if he hears of a problem he follows up on those.

Q: As far as personnel goes, maybe you could tell us how you manage conflict there.

A: If staff see conflict coming up between two nurses on a floor their supervisor sits them down and talks to them about it. If this is not successful, department heads are asked to look into the matter. If it's a disciplinary problem, the department head will first give them a verbal warning and the maximum will be a written warning. They are told they have to accept the rules and that's that.

An example might be . . . there was a problem with a nurse who couldn't get along with her co-workers. Our solution was to transfer her from her unit to another unit. Solutions like this aren't always so simple since other departments don't always have the flexibility to transfer their workers to another unit as the nurses do.

Q: Did you ever consider going to the co-workers and explaining the situation and asking for their cooperation with a troubled employee?

A: Well, that's a touchy subject. We have a bad grapevine problem here and I'm afraid if we handled it like that the whole hospital would know the troubled employee's personal affairs. We usually confront them on a superficial level by telling them we have a problem and asking them to bare with us.

Q: Do your administrators and employees ever have the opportunity to get together and discuss problems that arise?

A: The administrator is always willing to meet and discuss any problem with any employee at any time. We also have a suggestion box. Questions deposited in there go directly to the administrator. Some departments have monthly meetings but it's really up to them.

INTERVIEW C

Q: How do you solve conflicts and problems that arise with patients at ?

A: We talk to the patient to determine if the problem or complaint is legitimate. They speak to all parties involved in the conflict and legitimate or not they tell all members involved that "they've looked into it and they're handling it the best way they can." If it's a chronic complainer they try to give them a rational answer why things are the way they are.

Q: Do you instruct your nursing staff with any particular attitude to enter patient's rooms with?

A: It's hard to determine what any particular patient wants or needs from their nurse. They go in and talk to the patient and try to feel them out about it. Unless of course the patient has been in before . . then the staff already knows what attitude works best. In theory every patient is to have what is called a Nursing Care Plan. This is simply a blank sheet of paper that will have headings of 'Problems', 'Approaches', and 'Goals'. As I said before it is supposed to be used for every patient but it really isn't necessary for stays of one to two days. We always use it for our chronic patients.

Q: What approach do you use for fearful chronic patients?

A: We use the Team Nursing Approach. We've only been using it for about a year at . What is done with Team Nursing is, the nurses will have a conference about the patient then come up with a strategy and goals are set to deal with the patient. We try to assign nurses to patients that are best equipped in handling that patient's problems.

Q: How do you go about alleviating fears in patients that are angry or withdrawn?

A: We play it by ear. We use alot of public relations and diplomacy. What works in theory doesn't always work 100% in practical application.

INTERVIEW D

Q: What do you do to avoid hostility and conflict here at Hospital?

A: With patients we have a patient representative. She makes rounds routinely to see new patients and she can be called by any nurse in the hospital, and frequently is, about any complaint, about anything, about their bill or anything else. She is strictly for the patient and she does everything in her ability to help satisfy this patient. Now with employees, one thing I think is very important and isn't done too much in other hospitals, o r president holds open meetings with the employees about 3 times a year and these are scheduled through the day for, two days really, and they can ask him any question they want. I'm usually there with him at the meetings because sometimes there are questions about personnel policies that he would not have the answers to. So between the two of us, we try to answer their questions right there. They often give suggestions and I take notes on everything that is brought up at these meetings. If they can't be answered then it's considered and answers are given back through our Dialogue (the hospital newspaper). We have a Friday Dialogue and employees can write in a question, suggestion or anything like that and it's assigned to the person most able to answer the question. Even before the answer is given, it goes through our administrative group to be sure that the question has in fact been answered. This is another means of getting employee input to management.

Q: Is there some way that you train your staff to deal with patients who may be fearful and in turn hard to handle?

A: On our staff we have a psychiatric coordinator and these people are trained to approach patients with specific emotional problems. They not only provide consultations to the psychiatric patient, but also to any patient who is having a real emotional problem that is too difficult for the nurse on the floor to handle and they can also call upon these coordinators to assist them to help

with the patient.

Q: And would they then go and speak with the patient?

A: Oh yes! They would go and speak with the patient to see what it was that was upsetting them. And we also have in-service education going on for our people in stress management. We've had special people come in to help personnel deal with the stress of their jobs particularly in our intensive care unit where the type of work is so stressful. These people need more help than others. Another way to get to the employees is, I've recently started making rounds of all departments once a week, just to make myself available to the employees. They can see me, they know I'm there and that I care. Mr. , our President, makes rounds and of course our Vice-President of patient care makes rounds. So we try to get out to see all the people and be available for any questions they have.

Q: Do you instruct your staff specifically with any kind of attitude to go into patient's rooms with?

A: Our nursing personnel has developed a patient evaluation and is trained very closely to go in and evaluate the patient's needs. According to this evaluation of what this patient's needs are, they respond with what we call problem-oriented clarity and approach.

Q: Do the patients get a chance to evaluate the hospital staff?

A: Our patient representative sees the patients and gets a questionnaire to them. The patient can fill it out and of course she gets it verbally too.

Q: Would you say on a whole that you don't have too many problems with the patients here? Because it seems that you're taking a pretty modern approach to this. Would you say you have satisfied customers?

A: From what we've heard through letters from patients after they go home, yes.

Q: What do you think that does for someone's recovery?

A: Well, we have had a shorter hospital stay than many other hospitals because of it. Studies have shown that if you can allay their fears they're going to progress much faster and with less complications.

Q: I would think that would be the big thing, having the patients overcome their fear, no matter how small the reason they're in here, the idea of being in a hospital just has negative affects. Different people fear different things. What may be fearful to one patient may not be fearful to another. What would you do, or how would you go about alleviating fears in a patient who didn't quite know why he or she was afraid?

A: If a patient is fearful, and we always go by the assumption that any patient in the hospital is fearful. (They may exhibit this in many different ways.) They may withdraw and not say anything. This takes patience and frequent contacts to establish a one-to-one relationship so that you can develop a basic trust, then they can feel free to express themselves.

Q: I've heard about your tours for children where they take them through the hospital and show them around so they become more accustomed to it before they ever have to stay at one. How has that program been working out?

A: We have a male nurse who loves to show the children the monitors and take them around the hospital. They love him and he loves them. It's worked out very well. We've had some very positive feedback from the schools in the area.

Q: Do you have any problem with conflicts between the staff?

A: Yes, we do, from time to time. Of course being aware of it is the first thing. It's handled in many different approaches. The best thing to do is I myself

held some classes in transactional analysis to try to bring out their feelings and work through them. I've had 5 groups, 3 of them successful. At least we're aware of the need to take action and not just let it ride and eventually blow up. Sometimes we have conflicts that none of us feel we can handle. We don't hesitate to call in a psychiatrist or psychologist.

Q: Where do you find most of your conflict?

A: I can't say there's any particular area that causes most of the conflict. You'll sometimes, and this is traditional in nursing, I'll see a conflict between the shift coming on and the shift going off, not getting the work done. Usually that can be resolved through meetings. Our nursing staff has unit meetings every month that lets them bring up their feelings and resolve them. This gives them a better understanding of each other's needs. We're not perfect, but we're as perfect as we can be right now.